



Traumatic brain injury patients: direct versus inter-facility transfer time to neurosurgical center and the effects on outcome

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Background: *Traumatic brain injury (TBI) is one of the leading causes of death world-wide. Trauma system helps quick transfer of patients to trauma centers. Lack of organized trauma system leads to delay in transferring neurosurgical patients to neurosurgical centers. The main objective of this study was to determine the time lag in TBI patients transferred from trauma scene and those referred from other health facilities to neurosurgical center and the effects on outcome and hospital stay.*

Methods: *It was a prospective study of TBI patients managed by our neurosurgical center from November 2010 to October 2013. Patients' data were collected in accident and emergency, wards and out-patient clinic using structured proforma that was component of our prospective data bank that was approved by Ethics Committee. The data was analyzed using Epi Info 7 Software.*

Results: *Two hundred and twenty one patients were studied. There were 166 males. One hundred and one patients came direct from trauma scene. The median time to neurosurgical review was 5 hours for direct and 28 hours for referred patients. Mode of presentation did not affect the outcome and hospital stay significantly.*

Conclusion: *Mode of presentation did not affect the outcome and hospital stay significantly.*

Key words: traumatic brain injury, direct transfer, referred, outcome, hospital stay

Introduction

Traumatic brain injury is often referred to as 'the silent epidemic', causing great personal suffering to victims and relatives and economic burden to the society.^{1,2} Brain Trauma Foundation pre-hospital guidelines recommends direct transport of patients with TBI to hospitals with availability of neurosurgical care including CT scanning, intracranial monitoring and treatment.³ Direct transport of patients from trauma scene to specialized trauma centers has been shown to significantly increase survival.⁴ We studied time lag for patients transported direct from trauma scene and those referred from other health facilities to our neurological center, and its effects on outcome and hospital stay.

Patients and Methods

It was a prospective descriptive study of traumatic brain injury patients admitted and managed by our neurosurgical center from 1st November 2010 to 31st October 2013. Data was collected using structured proforma which was a component of our prospective Data Bank that was approved by our hospital Research and Ethics Committee. Data was collected in accident and emergency, wards and out-patient clinic. Biodata, time of trauma, etiology, place of first medical care, mode of presentation (DIRECT = from the scene, INDIRECT = referred from other health facilities), time patient arrived in accident and emergency, time neurosurgical unit reviewed the patient, Glasgow Coma Score after resuscitation, mode of treatment given, length of stay in the hospital, and Glasgow Outcome Score three months post-injury were collected. The functional outcome was assessed at three months post-injury as it had been found that the outcome at three months is the best predictor in long term.⁵ Patients excluded from the study

included those whose time of trauma or presentation were not known, patients that were not admitted, and those referred to our clinic for post-traumatic complications such as post-concussion syndrome, frontal lobe syndrome and post-traumatic seizures. The data was analyzed using Epi Info 7 software.

Results

Two hundred and twenty one patients qualified for the study. There were 166 males and 55 females. The age range was two months to 75 years with mean age of 28.08 years. Twenty to thirty year age group had the highest frequency (Table 1).

Table 1. Age Distribution

Age	Number	Percent (%)
0 -10	41	18.55
10 – 20	29	13.12
20 – 30	60	27.15
30 – 40	50	22.62
40 – 50	27	12.22
50 – 60	9	4.07
60 – 70	4	1.81
70 - 80	1	0.45
Total	221	100

One hundred and one patients (45.7%) came direct from the trauma scene (direct group), while 120 patients (54.3%) were referred from other health facilities (indirect group). The median time of reaching our accident and emergency was 2 hours for direct group and 20 hours for indirect group (Table 2). There was significant delay for the indirect group relative to the direct group $P = 0.0000$.

Table 2. Time Lag from Trauma Scene to Accident and Emergency.

DIRECT								
Time lag (hours)	Number	total	Mean	variance	Std dev	min	Median	Max
	101	444	4.40	146.78	12.12	1.00	2.00	94.00
INDIRECT								
Time lag (hours)	Number	total	Mean	variance	Std dev	min	Median	Max
	120	5077	42.31	3808.65	61.71	1.00	20.00	336.00

Table 3. Time Lag from Trauma Scene to Neurosurgical Care

DIRECT								
Time lag (hours)	Number	total	mean	variance	Std dev	min	median	Max
	101(45.7%)	1182	11.70	288.97	16.99	2.00	5.00	95
INDIRECT								
Time lag (hours)	Number	total	mean	variance	Std dev	Min	median	Max
	120(54.3%)	5793	48.27	3814.08	61.75	2.00	28.00	337

The median time from time of trauma to neurosurgical review was 5 hours for direct and 28 hours for indirect groups (Table 3). The median time between presentation in accident and emergency and neurosurgical review was 3 hours for direct and 2 hours for indirect group. The commonest etiology was road traffic accident (Table 4).

Table 4, Distribution of Causes of TBI

Etiology	Number	Percent (%)
Road traffic accident	158	71.49
Assault	26	11.76
Fall	24	10.86
Gun shot	4	1.81
Sports	2	0.90
Others	7	3.17
Total	221	100

One hundred and sixty nine patients (76.47%) were managed conservatively, while 52 (23.53%) had surgical care. Mode of treatment did not affect the overall outcome $P = 0.0937$. Favorable outcome ($GOS \geq 4$) was 91.4% and mortality was 8.14%. The mortality among the direct group was 10.89% while the indirect group had 5.83%. There was no significant difference in outcome between the two groups $P = 0.3969$ (Table 5). The median hospital stay was 11 days for direct group and 14 days for indirect group (Table 6) Mode of presentation did not have significant effect on hospital stay $P = 0.5283$.

Table 5. Mode of Presentation Versus Glasgow Outcome Score

Mode of presentation	Glasgow Outcome Score				
	1	3	4	5	Total
Direct	11(10.89%)	0 (0.00%)	11 (10.89%)	79 (78.22%)	101 (100%) 45.70%
Indirect	7 (5.83%)	1(0.83%)	11(9.17%)	101(84.17%)	120 (100%) 54.30%
Total	18 (8.14%)	1(0.45%)	22 (9.95%)	180 (81.45%)	221 (100%)
$P = 0.3969$					

Table 6. Hospital Stay

DIRECT								
Hospital stay (days)	Number	total	mean	variance	Std dev	min	median	Max
	101	1886	18.67	819.30	28.62	1.00	11.00	213.00
INDIRECT								
Hospital stay (days)	Number	total	mean	variance	Std dev	min	median	Max
	120	2095	17.46	276.10	16.62	1.00	14.00	122.00

Discussion

We had 221 patients in our study with 75.11% males. High percentage of males in traumatic brain injury had been documented in many series.^{2-4, 6-12} It had been attributed to high activities of males trying to fend for the families.

One hundred and one patients (45.7%) were transported from the trauma scene to the neurosurgical center while 120 patients (54.3%) were referred from other health facilities. The median time for direct group was 5 hours while in indirect group it was 28 hours. The arrival time for indirect group was significantly greater than the direct group $P = 0.0000$. These times were outside the North American guidelines which recommended a maximum of 4 hours from time of injury to neurosurgical attention for patients requiring hematoma evacuation.¹³ In 170 patients studied in Auckland by Kejriwal et al¹⁰ 57% came direct while 43% was indirect, and the median time was 50 minutes and 7 hours 3 minutes respectively. There was significant delay by the indirect group $P = 0.0001$. There was trauma system with patients from most distant referring hospital, 346km from Auckland, transferred via air ambulance. The neurosurgical center covered a population of approximately 2 million people. In 151 patients studied in United Kingdom between 1982 and 1984 by Marsh et al,¹² 17 patients were direct while 134 patients were indirect. They found that patients remained average of 12 hours in District General Hospital before neurosurgical unit was contacted. They also noted that the average ambulance journey was 20 minutes for hospitals less than 10 miles and 35 minutes for those greater than 20 miles. Their neurosurgical centers covered population of 1.5-3 million people. They had a ratio of one neurosurgeon to 500,000 of population then which had improved to 1:254,063.¹⁴

Our neurosurgical centre with one neurosurgeon covers two states and parts of three adjoining states all totaling approximately 7 million people and the city the center is located has population of 431,200 people.¹⁵ We got referral from health facilities in these states. There was no trauma system. Patients were transferred by road and farthest areas are about 600km. It took average of 6 hours to bring some of the patients from far areas. Indirect group in our study was higher because majority of patients were living outside the city the neurosurgical center is located. The need to resuscitate these patients in the nearest hospital before referring to the neurosurgical center, and the distance covered to reach the neurosurgical center must have accounted for the significant delay in the indirect group. The time taken from arrival of these patients at the accident and emergency to neurosurgical team review (3 hours for direct and 2 hours for indirect) was unacceptably high. The delay in informing neurosurgical team when these patients arrived prompted this study. This is likely to transcend to other units. It serves as a clarion call for better organization of the accident and emergency.

In our study, there was no significant difference in functional outcome and mortality, and hospital stay among the two groups. Nathens et al¹⁶ retrospectively studied 4,720 patients and found no significant difference in mortality and length of hospital stay in both direct and indirect groups. However, the cost of treatment was significantly higher in the indirect group. Raj et al¹⁷ studied 431 patients and found median time of 1.07 hours for direct group and 4.06 hours for indirect group. There was no significant difference in mortality between the two groups. They believed that the delay was not long enough in their study. This belief was not supported by our study which had long delay (median was 5 hours for direct and 28 hours for indirect) but still no significant difference in mortality and hospital stay. Like our study there were more deaths among the direct group. Moen et al⁸ also found more deaths among the direct group in their study. Their study as well as Nathens et al had more severe head injuries in patients admitted direct to neurosurgical center. In our study severe head injury was 19.80% in direct group and 22.17% in indirect group. The higher mortality among the direct group might

have been due to the fact that many of them travelled long distances without resuscitation unlike the referred patients who were resuscitated in referring hospitals. Härtl et al⁹ showed that patients transported indirectly to neurosurgical trauma center via a lower level of care hospital had a 50% higher risk of death than patients transported direct. Many authors also found higher mortality among referred group.¹⁸⁻²¹ That had been attributed to presence of trauma system²²⁻²⁴ which helped in faster transfer of patients to neurosurgical centers. This is supported by finding that the presence of trauma system has been associated with decreased mortality and improved outcomes by potentially speeding up transfer of trauma patients to a major trauma center.^{23,24} However, Sollid et al²⁵ studied 85 severe head injury patients in which 47 was transported direct to neurosurgical center and 37 referred from other hospitals. They found more deaths (34%) and lower favorable outcome (53%) among direct group compared to mortality of 26% and favorable outcome of 58% among the referred patients. The difference among the groups was not statistically significant.

Myburgh et al²⁶ studied prospectively 635 adult patients with TBI in a trauma system and adherence to international guidelines, and found mortality and favorable outcome similar to data published before the advent of guidelines. They concluded that the mortality was likely from pre-hospital secondary brain insult and ageing population. They advised that strategies should be directed at preventive public health strategies and intervention to minimize secondary brain injuries in the pre-hospital period. This advice is apt considering that the study by Thibault et al²⁷ on 297 patients on pre-implementation, implementation, and post-implementation of guidelines failed to improve times to neurosurgical care. The implementation of these guidelines has also been very poor. A Canadian study found fewer than 40% of physicians changed their practice on the basis of any guidelines.²⁸ In United States, only 16% of centers achieved full guideline compliance on the management of severe traumatic brain injury in 2002.²⁹ Chafi et al³⁰ in their current publication still found suboptimal adherence to guidelines in America with overall average of 73%.

Conclusion

Our study showed that majority of our patients was referred from other health facilities. There was significant delay in patients accessing neurosurgical care in our center by patients referred from other health facilities compared to those coming to us from trauma scene. Our result showed that there was no significant difference in mortality and hospital stay among patients coming direct from trauma scene and those referred from other health facilities.

Recommendation

Upgrading general hospital facilities such as provision of CT scans and Telemedicine facilities will help Doctors in general hospital to communicate with neurosurgeons in neurosurgical centers for quick evaluation of patients and quick institution of appropriate treatment. . More attention should be paid to prevention of secondary brain injuries from the accident scene to the definitive neurosurgical care.

Establishment of trauma system with air and land ambulances will help faster transfer of patients to neurosurgical centers for appropriate and adequate treatment. Urgent steps have to be taken to reduce the time taken to review patients in accident and emergency. The hospital should provide communication gadgets to accident and emergency unit, and other units for prompt communication and quick response.

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